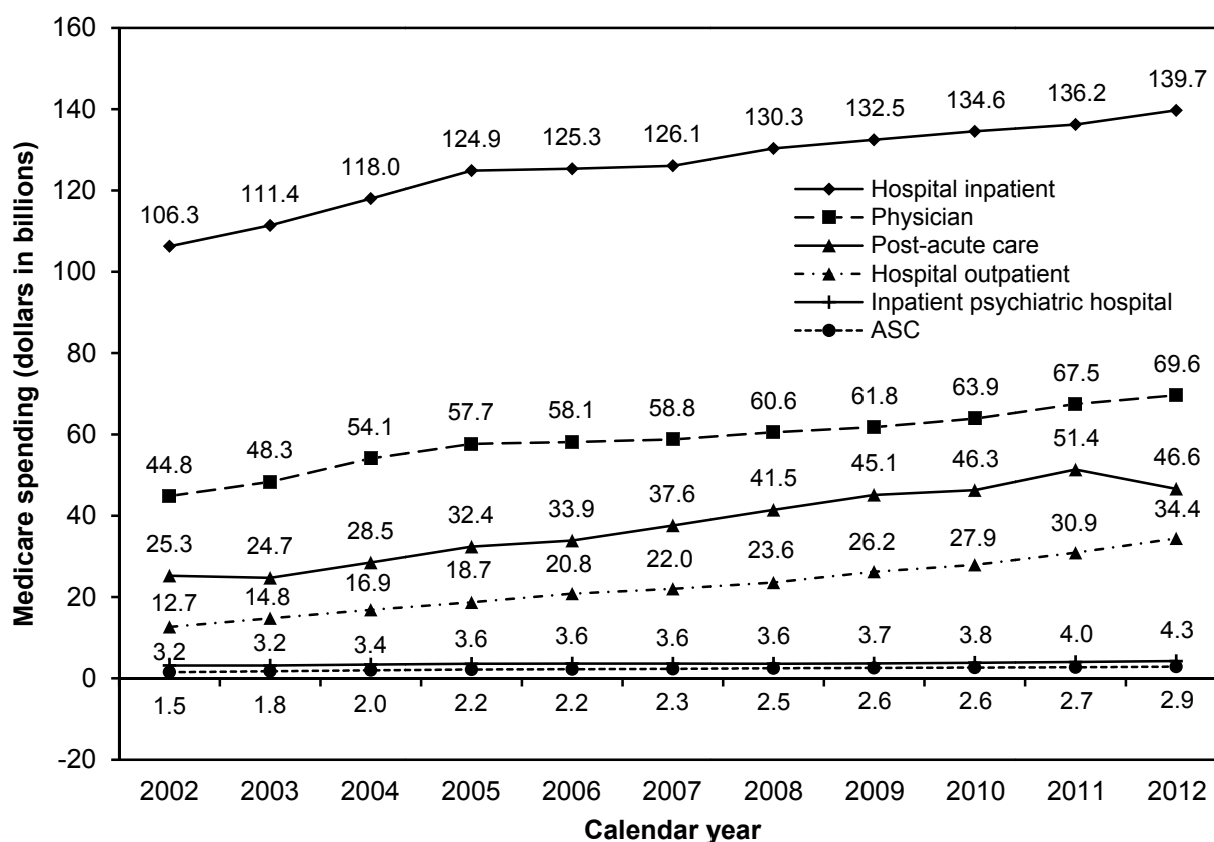


SECTION

1

**National health care and
Medicare spending**

Chart 1-1. Aggregate Medicare spending among FFS beneficiaries, by sector, 2002–2012

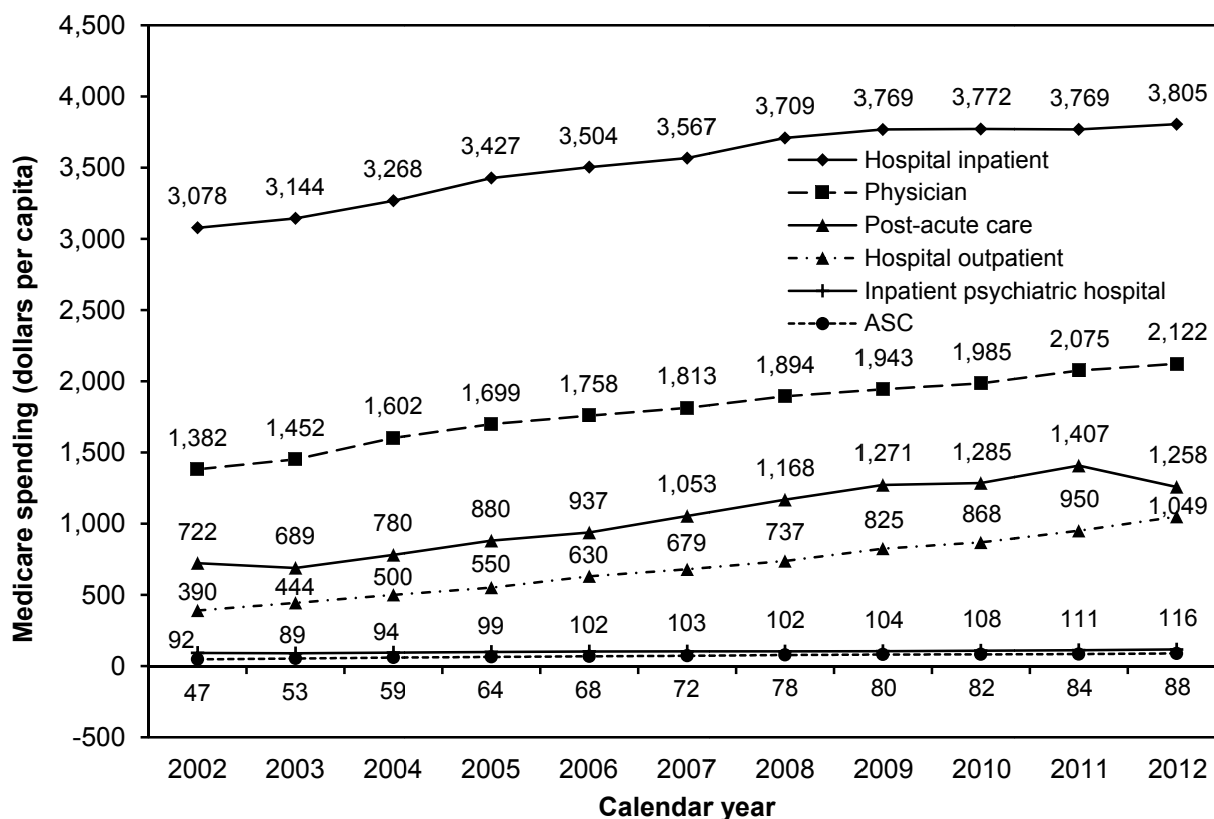


Note: FFS (fee-for-service), ASC (ambulatory surgical center). Post-acute care includes spending on home health services and skilled nursing facilities. Dollars are Medicare spending only and do not include beneficiary cost sharing. Spending for Medicare Advantage enrollees is also not included.

Source: CMS Office of the Actuary and the 2012 and 2013 annual reports of the Boards of Trustees of the Medicare Trust Funds.

- Medicare spending among FFS beneficiaries has increased significantly since 2002 across all sectors even though spending growth has slowed since 2006. The slowdown in spending growth is partially attributable to a decline in the growth of FFS enrollment as the number of Medicare Advantage enrollees increased.
- Spending growth for hospital inpatient services, the sector with the highest level of spending, was strong from 2002 through 2005, averaging 5.5 percent per year. Since 2006, spending growth has averaged 1.8 percent per year. That slowdown is partially attributable to a shift in service volume from the inpatient setting to the outpatient setting as well as to the decline in the growth of FFS enrollment (as more beneficiaries enrolled in Medicare Advantage), but it may also reflect broader economic conditions.

Chart 1-2. Per capita Medicare spending among FFS beneficiaries, by sector, 2002–2012

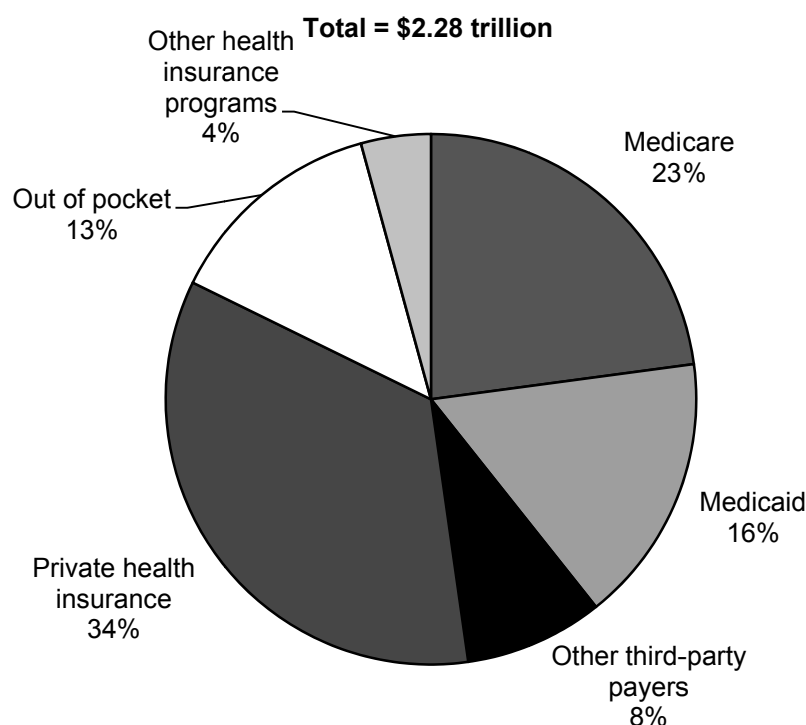


Note: FFS (fee-for-service), ASC (ambulatory surgical center). Post-acute care includes spending on home health services and skilled nursing facilities. Dollars are Medicare spending only and do not include beneficiary cost sharing. Spending for Medicare Advantage enrollees is also not included. Spending per beneficiary for hospital inpatient services and inpatient psychiatric hospital services equals spending for the sector (Chart 1-1) divided by FFS enrollment in Part A. Spending per beneficiary for physician services, hospital outpatient services, and ASC services equals spending for the sector (Chart 1-1) divided by FFS enrollment in Part B. Spending per beneficiary for post-acute care services equals spending for the sector (Chart 1-1) divided by total FFS enrollment.

Source: CMS Office of the Actuary and the 2011, 2012 and 2013 annual reports of the Boards of Trustees of the Medicare Trust Funds.

- Medicare spending per beneficiary in FFS Medicare has increased substantially since 2002 across all sectors even though the growth in spending per beneficiary has slowed since 2006.
- Spending per beneficiary for hospital inpatient services, the sector with the highest level of spending, grew 3.6 percent per year from 2002 through 2005. Since 2006 growth in spending per beneficiary for hospital inpatient services averaged 1.4 percent per year. Spending per beneficiary for hospital outpatient services has had robust growth in each year, averaging over 10 percent per year over the time period.

Chart 1-3. Medicare made up over one-fifth of spending on personal health care in 2011

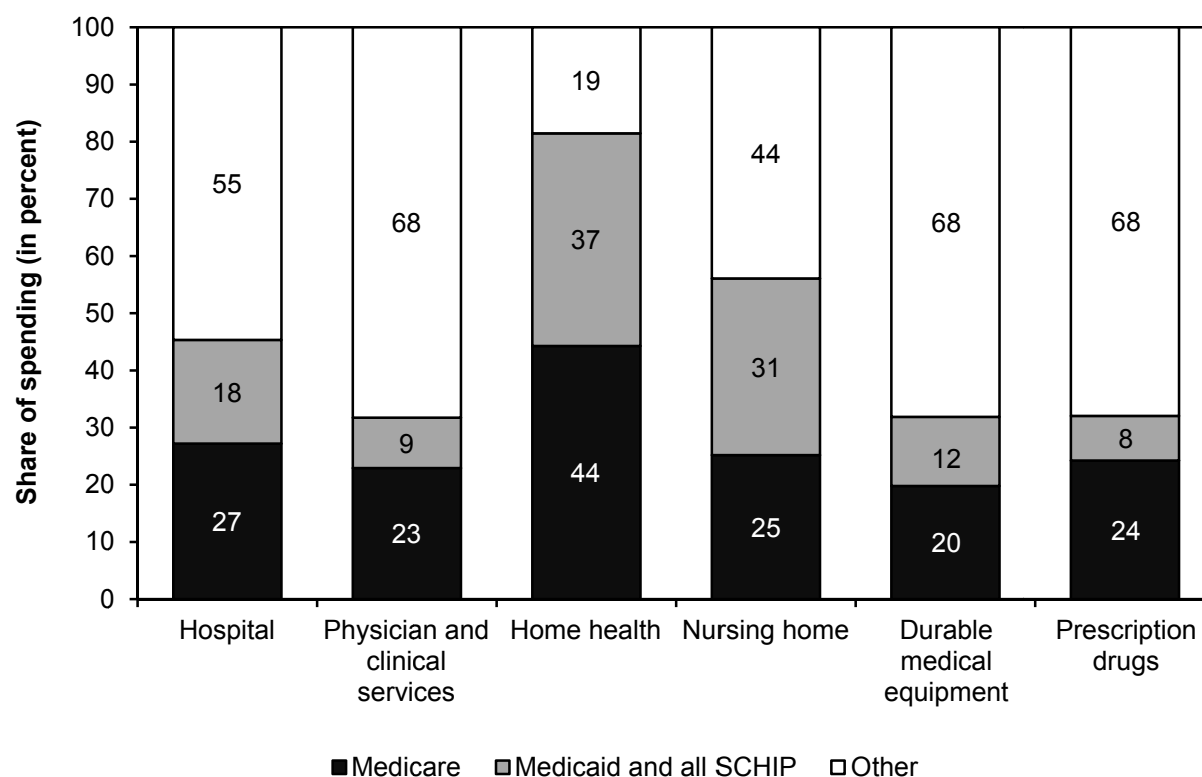


Note: All data are for calendar year 2011. Out-of-pocket spending includes cost sharing for both privately and publicly insured individuals. Personal health care is a subset of national health expenditures. It includes spending for all medical goods and services that are provided to treat or prevent a specific disease or condition in a specific person and excludes other spending, such as government administration, the net cost of health insurance, public health, and investment. Premiums are included with each program (e.g., Medicare, private insurance) rather than in the out-of-pocket category. Other health insurance programs include the Children's Health Insurance Program, Department of Defense, and Department of Veterans' Affairs. Other third-party payers include worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health. Numbers do not add to 100 percent due to rounding.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, 2013.

- Medicare is the largest single purchaser of health care in the United States. Of the \$2.28 trillion spent on personal health care in 2011, Medicare accounted for 23 percent, or \$522 billion (as noted above, this amount includes direct patient care spending and excludes certain administrative and business costs).
- Thirty-four percent of spending was financed through private health insurance payers and 13 percent was from consumer out-of-pocket spending.
- Medicare and private health insurance spending include premium contributions from enrollees.

Chart 1-4. Medicare's share of spending on personal health care varies by type of service, 2011

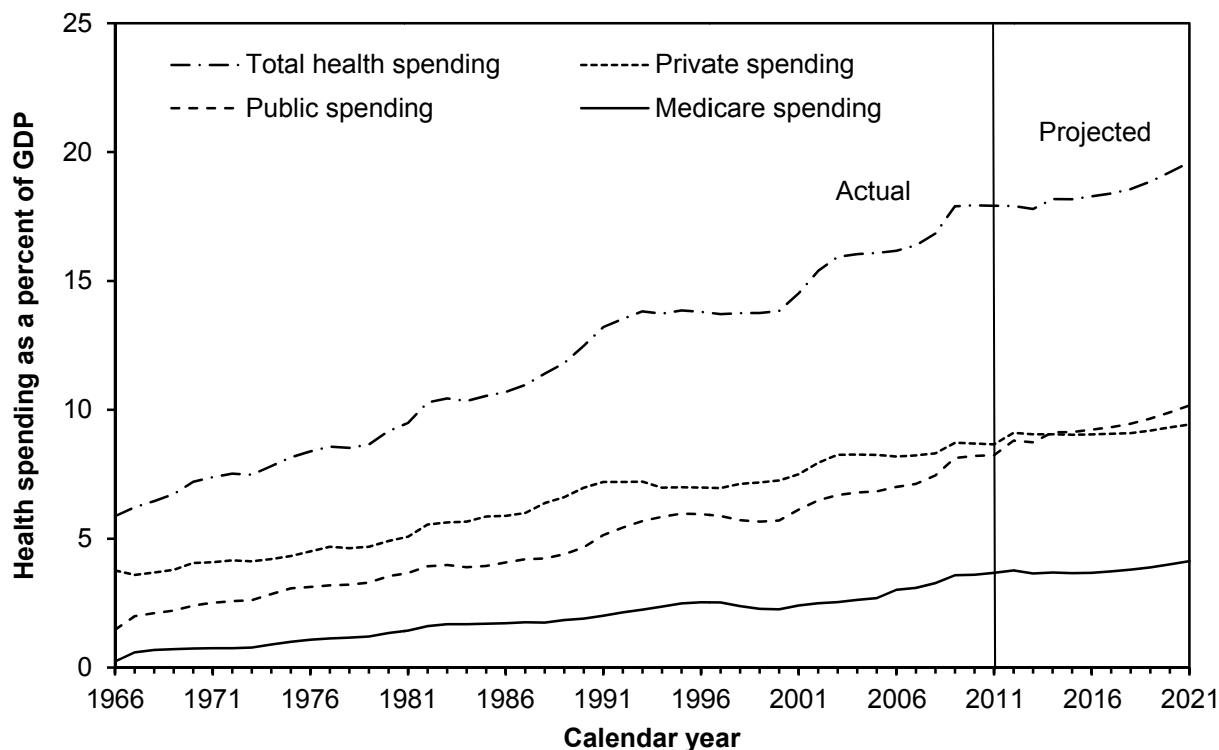


Note: SCHIP (State Children's Health Insurance Program). All data are for calendar year 2011. Personal health care is a subset of national health expenditures. It includes spending for all medical goods and services that are provided to treat or prevent a specific disease or condition in a specific person and excludes other spending, such as government administration, the net cost of health insurance, public health, and investment. Totals may not sum to 100 percent due to rounding. "Other" includes private health insurance, out-of-pocket spending, and other private and public spending.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, 2013.

- While Medicare's share of total spending on personal health care was 23 percent in 2011, its share of spending by type of service varied, with a slightly higher share of spending on hospital care and a much higher share of spending on home health services, partly because that category, in the chart above, includes hospice services.
- Medicare's share of spending on nursing homes was smaller than Medicaid's share because Medicare pays for nursing home services only for Medicare beneficiaries who require skilled nursing or rehabilitation services, whereas Medicaid pays for custodial care (assistance with activities of daily living) provided in nursing homes for people with limited income and assets.
- In 2011, Medicare accounted for 27 percent of spending on hospital care, 23 percent of physician and clinical services, 44 percent of home health services, 25 percent of nursing home care, 20 percent of durable medical equipment, and 24 percent of prescription drugs.

Chart 1-5. Health care spending has grown more rapidly than GDP, with public financing making up nearly half of all funding

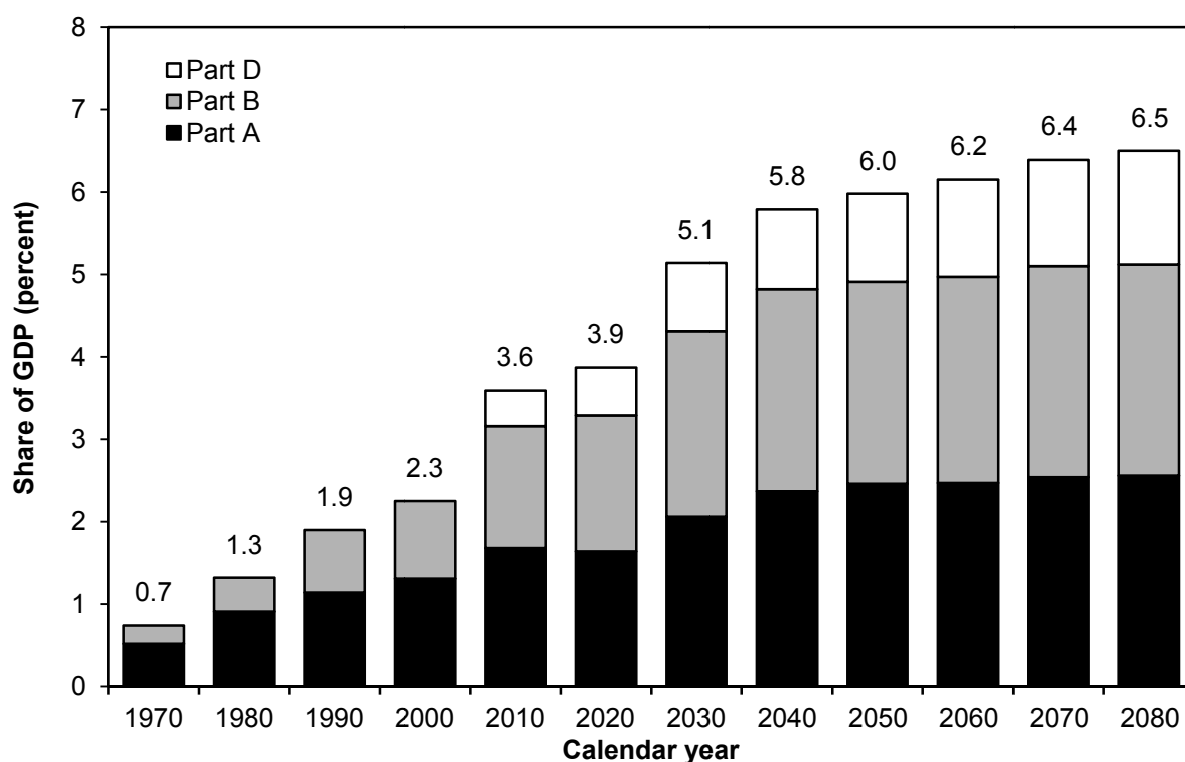


Note: GDP (gross domestic product). Total health spending is the sum of all private and public spending. Medicare spending is one component of all public spending.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, 2013.

- Total health care spending consumes an increasing proportion of national resources, accounting for a double-digit share of GDP annually since 1982.
- As a share of GDP, total health care spending increased from about 6 percent in 1966 to about 18 percent in 2009 and remained at 18 percent in 2010 and 2011. Projections suggest that total health care spending will make up 19.6 percent of GDP by 2021.
- Medicare spending has also grown as a share of the economy from less than 1 percent at the introduction of the program in 1966 to 3.6 percent in 2012. Projections suggest that Medicare spending will make up 4.0 percent of GDP by 2021.
- In 2011, public spending made up 49 percent of total health care spending and private spending made up 51 percent. By 2014 public spending is projected to begin to exceed private spending. By 2021, public spending is projected to be 52 percent of total health care spending and private spending is projected to be 48 percent.

Chart 1-6. Trustees project Medicare spending to increase as a share of GDP

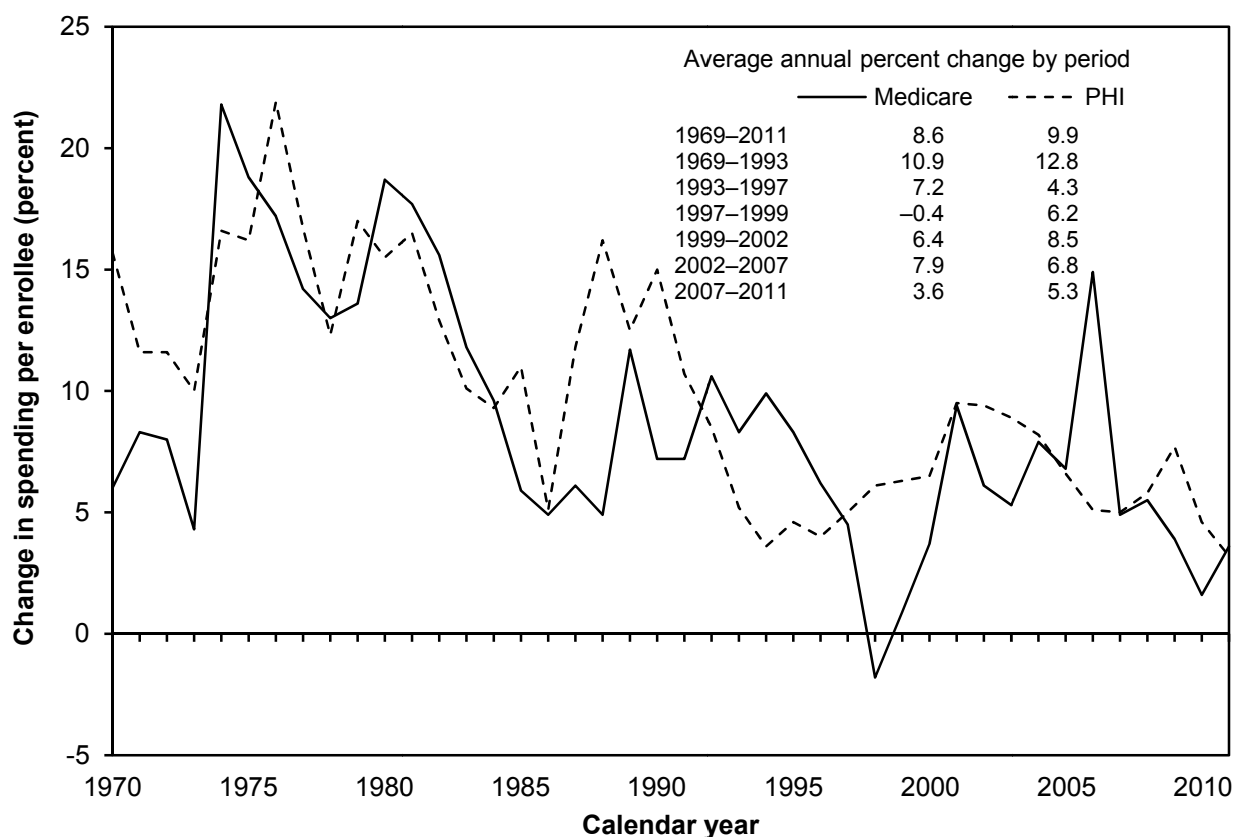


Note: GDP (gross domestic product). These projections are based on the trustees' intermediate set of assumptions.

Source: 2013 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Over time, Medicare spending has accounted for an increasing share of GDP. From less than 1 percent in 1970, it is projected to reach 6.5 percent of GDP in 2080
- The Medicare trustees project that spending will rise from 3.6 percent of GDP in 2012 to 5.1 percent of GDP by 2030, largely due to the rapid growth in the number of beneficiaries, and then to 6.5 percent of GDP in 2080, with growth in spending per beneficiary becoming the larger factor in later years of the forecast. The rapid growth in the number of beneficiaries began in 2011 and will continue to 2030 as members of the baby-boom generation reach age 65 and become eligible to receive benefits.
- Nominal Medicare spending grew on average 9.1 percent per year over the period from 1980 to 2010, considerably faster than nominal growth in the economy, which averaged 5.7 percent per year over the same time frame. Future Medicare spending is projected to continue growing faster than GDP, averaging 5.5 percent per year between 2010 and 2080 compared with an annual average growth rate of 4.6 percent for the economy as a whole. In other words, Medicare spending is projected to continue rising as a share of GDP but at a slower pace.

Chart 1-7. Changes in spending per enrollee, Medicare and private health insurance

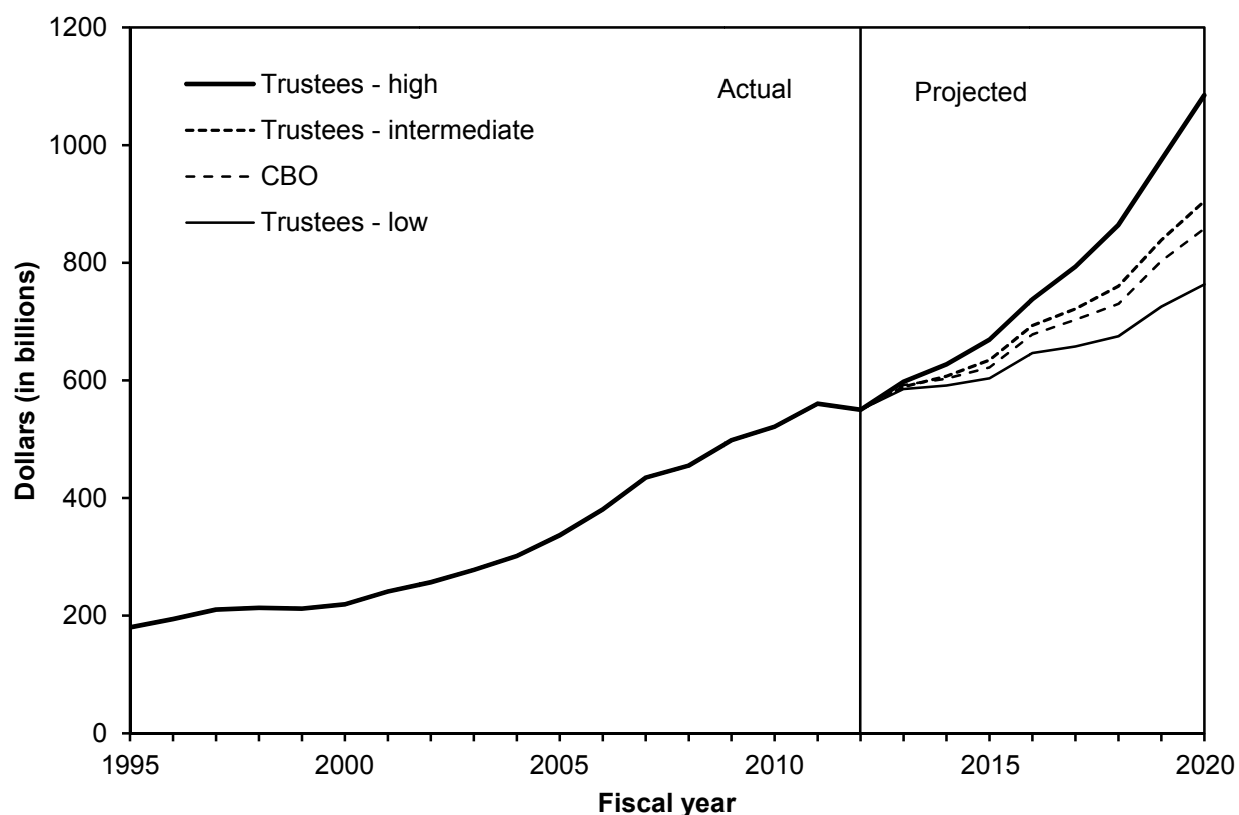


Note: PHI (private health insurance). Medicare expenditures include both fee-for-service and private plans.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, 2013.

- Although rates of growth in per capita spending for Medicare and private insurance often differ from year to year, over the long term they have been quite similar. However, this comparison is sensitive to the end points of the time one uses for calculating average growth rates. Also, private insurers and Medicare do not buy the same mix of services, and Medicare covers an older population, which tends to be more costly. In addition, the data do not allow analysis of the extent to which these spending trends were affected by changes in the generosity of covered benefits and, in turn, changes in enrollees' out-of-pocket spending.
- Differences appear to be more pronounced since 1985, when Medicare began introducing the prospective payment system for hospital inpatient services. Some analysts believe that, since the mid-1980s, Medicare has had greater success at containing cost growth than private payers by using its larger purchasing power. Others maintain that, since the 1970s, benefits offered by private insurers have expanded and cost-sharing requirements declined. These factors make the comparison problematic, since with the exception of the introduction of Part D in 2006, Medicare's benefits changed little over the same period.

Chart 1-8. Trustees project Medicare spending to grow at an annual average rate of 7.1 percent over the next 10 years; CBO projects an annual rate of 6.5 percent

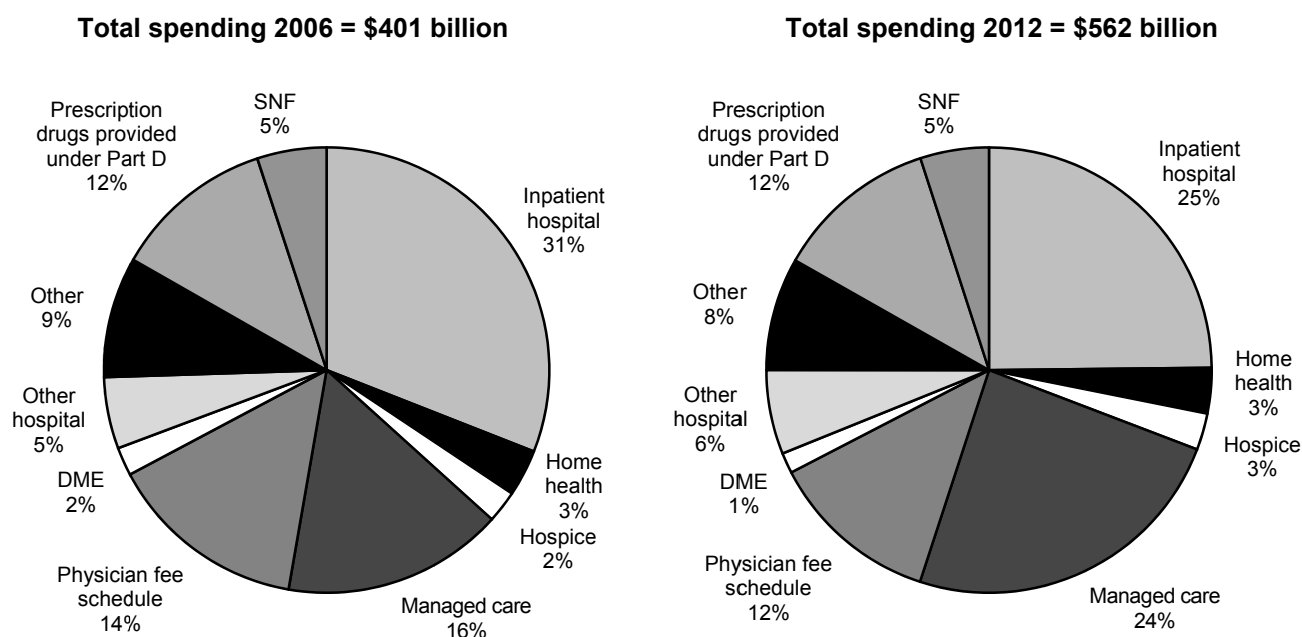


Note: CBO (Congressional Budget Office). All data are nominal, gross program outlays (benefit payments plus administrative expenses) by fiscal year.

Source: CMS Office of the Actuary and the 2006, 2011, and 2013 annual reports of the Boards of Trustees of the Medicare Trust Funds; CBO May 2013 baseline.

- Medicare spending has tripled since 1995, increasing from \$180 billion to \$550 billion by 2012 (these data are by fiscal year and include benefit payments and administrative expenses).
- CBO projects that spending for Medicare will grow at an average annual rate of 6.5 percent between 2012 and 2022. The Medicare trustees' intermediate projections for 2012 to 2022 assume 7.1 percent average annual growth. Forecasts of future Medicare spending are inherently uncertain, and differences can stem from different assumptions about the economy (which affect annual updates to provider payments) and about growth in the volume and intensity of services delivered to Medicare beneficiaries, among other factors.

Chart 1-9. Medicare spending is concentrated in certain services and has shifted over time

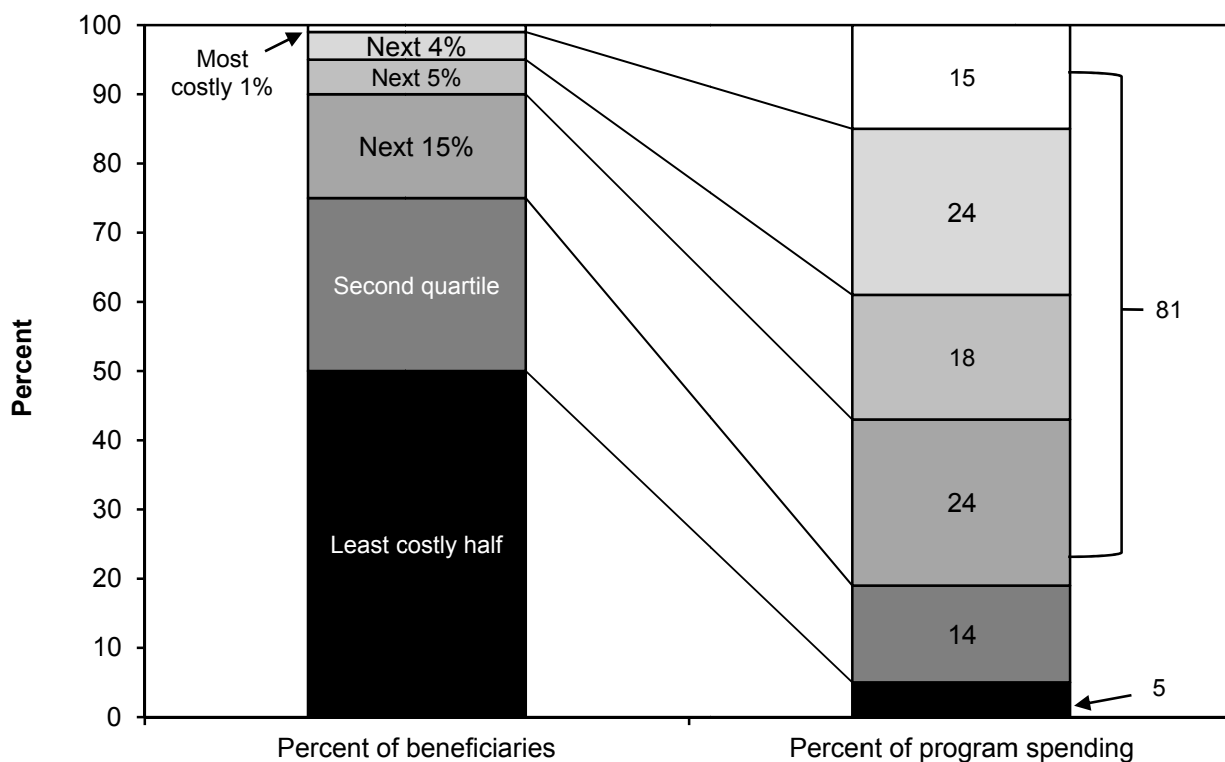


Note: SNF (skilled nursing facility), DME (durable medical equipment). All data are by calendar year. Dollars are Medicare spending only and do not include beneficiary cost sharing. "Other" includes carrier lab, other carrier, intermediary lab, and other intermediary. Totals may not sum to 100 percent due to rounding.

Source: CMS Office of the Actuary and the 2013 annual report of the Boards of Trustees of the Medicare Trust Funds.

- The distribution of Medicare spending among services has changed over time.
- In 2012, Medicare spent about \$560 billion for benefit expenses. Inpatient hospital services were the largest spending category (25 percent), followed by managed care (24 percent), services reimbursed under the physician fee schedule (12 percent), outpatient prescription drugs provided under Part D (12 percent), and other fee-for-service settings (8 percent).
- Although inpatient hospital services still made up the largest spending category, spending for those services was a smaller share of total Medicare spending in 2012 than it was in 2006, falling from 31 percent to 25 percent. Spending on beneficiaries enrolled in managed care plans grew from 16 percent to 24 percent over the same period. Medicare managed care enrollment has increased 86 percent over the same period.

Chart 1-10. FFS program spending is highly concentrated in a small group of beneficiaries, 2009



Note: FFS (fee-for-service). All data are for calendar year 2009. Analysis excludes beneficiaries with any group health enrollment during the year.

Source: MedPAC analysis of 2009 Medicare Current Beneficiary Survey, Cost and Use files.

- Medicare FFS spending is concentrated among a small number of beneficiaries. In 2009, the costliest 5 percent of beneficiaries accounted for 39 percent of annual Medicare FFS spending and the costliest quartile accounted for 81 percent. By contrast, the least costly half of beneficiaries accounted for only 5 percent of FFS spending.
- Costly beneficiaries tend to include those who have multiple chronic conditions, are using inpatient hospital services, are dually eligible for Medicare and Medicaid, and are in the last year of life.

Chart 1-11. Medicare HI trust fund is projected to be insolvent in 2026 under trustees' intermediate assumptions

Estimate	Year costs exceed income	Year HI trust fund assets exhausted
High	2008	2019
Intermediate	2008	2026
Low	2008	Never*

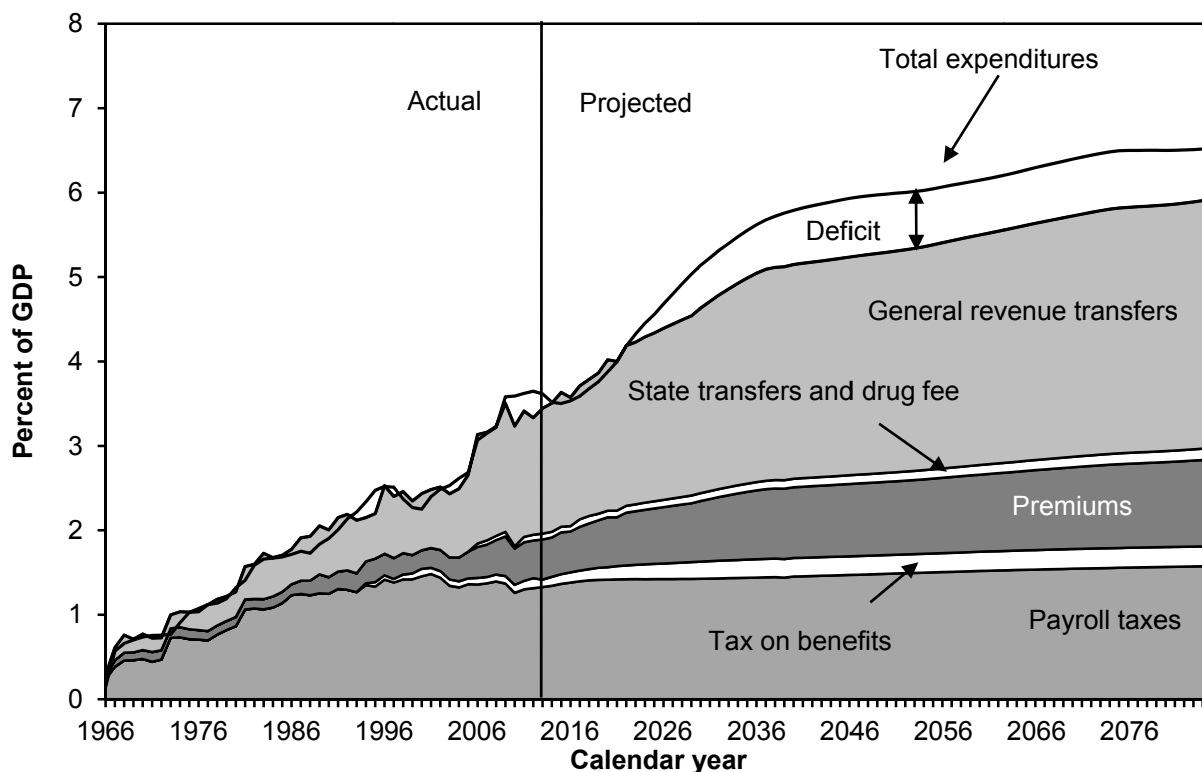
Note: HI (Hospital Insurance). All years represent calendar years. The primary source of income for HI is the payroll tax on covered earnings. Other HI income sources include a portion of the federal income taxes that Social Security recipients with incomes above certain thresholds pay on their benefits as well as interest paid on the U.S. Treasury securities held in the HI trust fund.

*Under the low-cost assumption, trust fund assets would start to increase in 2014 and continue to increase throughout the projection period.

Source: 2013 annual report of the Boards of Trustees of the Medicare Trust Funds.

- The Medicare program is financed through two trust funds: one for HI, which covers services provided by hospitals and other providers such as skilled nursing facilities, and one for Supplementary Medical Insurance (SMI) services, such as physician visits and Medicare's prescription drug benefit. Dedicated payroll taxes on current workers largely finance HI spending and are held in the HI trust fund. The HI trust fund can be exhausted if spending exceeds payroll tax revenues and fund reserves. General revenues finance roughly 75 percent of SMI services, and beneficiary premiums finance about 25 percent. (General revenues are federal tax dollars that are not dedicated to a particular use but are made up of income and other taxes on individuals and corporations.)
- The SMI trust fund is financed with general revenues and beneficiary premiums. Some analysts believe that the levels of premiums and general revenues required to finance projected spending for SMI services would impose a significant burden on Medicare beneficiaries and on growth in the U.S. economy.
- HI's expenses exceeded its income in 2008. In 2013, Medicare trustees report that, under the intermediate assumptions, the HI trust fund will be exhausted in 2026. Under high-cost assumptions, the HI trust fund could be exhausted as early as 2019. Under low-cost assumptions, it would remain able to pay full benefits indefinitely.

Chart 1-12. Medicare faces serious challenges with long-term financing

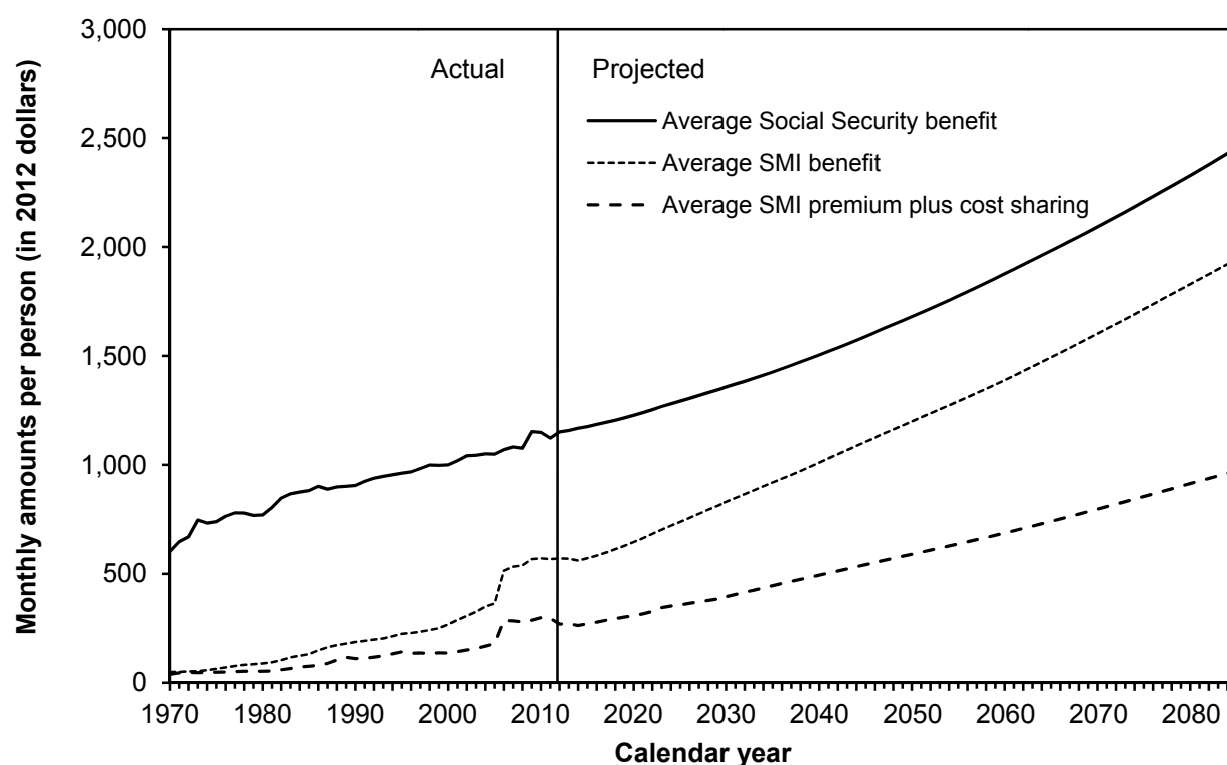


Note: GDP (gross domestic product). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to the portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending. The drug fee refers to the fee imposed in the Patient Protection and Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs. These fees are deposited in the Part B account of the Supplementary Medical Insurance trust fund.

Source: 2013 annual report of the Boards of Trustees of the Medicare Trust Funds.

- In 2012, Medicare expenditures exceeded Medicare revenues due to decreased Hospital Insurance payroll tax income caused by the weak economy. The Medicare trustees project that expenditures will continue to exceed revenues in 2013 and 2014.
- From 2015 to 2022, Medicare revenues are expected to exceed Medicare expenditures in part because expenditures are reduced as a result of provisions of the Budget Control Act of 2011 that require a 2 percent sequester of Medicare payments during this period.
- After 2022, the Medicare trustees project that Medicare expenditures will exceed Medicare revenues, and general revenues will grow as a share of total Medicare financing, adding significantly to federal budget pressures.

Chart 1-13. Average monthly SMI premiums and cost sharing are projected to grow faster than the average monthly Social Security benefit



Note: SMI (Supplementary Medical Insurance). Average SMI benefit and average SMI premium plus cost-sharing values are for a beneficiary enrolled in Part B and (after 2006) Part D. Beneficiary spending on outpatient prescription drugs before 2006 is not included.

Source: 2013 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Most Medicare beneficiaries pay their Part B premium by having it withheld from their monthly Social Security benefits. Over time, growth in Medicare premiums and cost sharing has outpaced growth in Social Security benefits.
- Between 1970 and 2010, the average monthly Social Security benefit (adjusted for inflation) increased by an annual average rate of 1.6 percent. Over the same period, average SMI premiums plus cost sharing grew by an annual average of 5.2 percent, and the value of the total SMI benefit grew by an annual average of 6.3 percent.
- The Medicare trustees project that growth in Medicare premiums and cost sharing will continue to outpace growth in Social Security income. Between 2010 and 2040 the average Social Security benefit is projected to grow by 1 percent annually (after adjusting for inflation), compared with about 1.7 percent annual growth in average SMI premiums plus cost sharing.

Chart 1-14. Medicare HI and SMI benefits and cost sharing per FFS beneficiary in 2011

	Average benefit (in dollars)	Average cost sharing (in dollars)
HI	\$5,172	\$435
SMI	4,992	1,272

Note: HI (Hospital Insurance), SMI (Supplementary Medical Insurance), FFS (fee-for-service). Dollars are for calendar year 2011 for FFS Medicare only and do not include Part D. Average benefits represent amounts paid for covered services per FFS beneficiary and exclude administrative expenses. Average cost sharing represents the sum of deductibles, coinsurance, and balance billing paid for covered services per FFS beneficiary.

Source: CMS Office of the Actuary; the 2013 annual report of the Boards of Trustees of the Medicare Trust Funds; and the Medicare and Medicaid Statistical Supplement 2012, CMS Office of Information Services.

- In calendar year 2011, the Medicare program made \$5,172 in HI benefit payments and \$4,992 in SMI benefit payments on average per beneficiary.
- In the same year, beneficiaries owed an average of \$435 in cost sharing for HI; \$1,272 in cost sharing for SMI; and a total of \$1,567 in cost sharing for both.
- Most Medicare beneficiaries have supplemental coverage through former employers, medigap policies, Medicaid, or other sources that fill in much of Medicare's cost-sharing requirements.

Web links. National health care and Medicare spending

- The Trustees' Report provides information on the financial operations and actuarial status of the Medicare program.

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html?redirect=/ReportsTrustFunds/>

- The National Health Expenditure Accounts developed by the Office of the Actuary at CMS provide information about spending for health care in the United States.

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html?redirect=/NationalHealthExpendData/>

- The Medicare & Medicaid Statistical Supplement developed by CMS provides statistical information about Medicare, Medicaid, and other CMS programs.

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/index.html?redirect=/MedicareMedicaidStatSupp/>

- CMS statistics listed in its Data Compendium provide information about Medicare beneficiaries, providers, utilization, and spending.

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/index.html?redirect=/DataCompendium/>

- MedPAC's March 2013 Report to the Congress provides an overview of Medicare and U.S. health care spending in Chapter 1, Context for Medicare Payment Policy.

http://medpac.gov/chapters/Mar13_Ch01.pdf